What is global mental health?

Looking back at 2020, historians will acknowledge the inescapable reality of global interconnectedness. Every country will have witnessed the health, social and emotional effects of the COVID-19 pandemic. For others, the outpouring of pent up anger, sadness and frustration due to generations of social inequities, exclusion, racism and discrimination – apparent both in the disparities in mortality revealed by COVID-19 and the persistent acts of structural and physical violence (highlighted among people of African descent in the US) – will be most vivid in retrospect. That these events have an emotional impact or more enduring effects on mental health will not be disputed. The appropriate responses to them – social, clinical, political, or some combination – can be debated. Such questions are ideally suited for the field of global mental health.

Global mental health is an evolving field of research and practice that aims to alleviate mental suffering through the prevention, care and treatment of mental and substance use disorders, and to promote and sustain the mental health of individuals and communities around the world[1]. It prioritizes equity, and is informed by many disciplines, including neuroscience, genomics, social sciences (especially psychology, medical anthropology and sociology), epidemiology, health services research, and implementation science. Advocacy plays a central role in the dissemination and translation of evidence into actionable policies and plans for communities, health systems and policy-makers to implement.

Global mental health activities are wide-ranging and intend to integrate a "reframed" mental health agenda into the 2030 Agenda for Sustainable Development[2]. This reframed agenda rests on four foundational pillars. The starting point is to recognize mental health as a global public good that requires action and intervention beyond the health sector. The second is adopting a dimensional approach that conceptualizes mental health as a continuum from wellness to illness, allowing equal emphasis on the prevention and treatment of mental disorders alongside the promotion and maintenance of mental health. The third pillar underscores the convergence of sociocultural experience and environmental context, genetics, neurodevelopment and psychology on brain biology to produce subjective experiences of mental health or distress. Consequently, our understanding of mental health and our ability to intervene lie at the intersection of multiple sources of knowledge. The fourth makes human rights a central tenet of global mental health action, and emphasizes the critical role that people with lived experience of mental health conditions must play in shaping prevention, care and research.

To achieve the aims of global mental health, several actions are proposed for policy-makers, funders, health system managers, advocates, and communities. Among these are the use of policies to address upstream social determinants of mental health; the scaling of mental health services and the integration of mental health into other global health priorities, from HIV/AIDS to non-communicable disease care; targeting sensitive periods of development by investing in the mental health and well-being of young people; the application of innovative approaches to extend mental health care; and the call for more financial investment in the sustained implementation of preventive measures and treatment interventions as well as in research across the relevant disciplines.

Research funding of the past decade shaped many of the current dominant themes in the field, such as task-sharing to extend human resources for mental health, and integrating mental health into global health priorities via community-based platforms both in and outside of the health care sector. The Grand Challenges in Global Mental Health, a research priority-setting exercise, distilled the insights of more than 400 participants from 60 countries around the world and specified the need for science along the translational continuum from discovery to policy research[3]. The most frequently espoused of the 40 challenges calls for primary prevention of mental disorders. Others speak to the need to enable family and community environments that support mental health, understand adaptive and resilient responses to daily life stressors, and establish cross-national evidence on factors underlying mental health disparities – all of which are relevant to the urgencies of 2020.

The authors of the Grand Challenges emphasized its global relevance, distinct from a focus on low- and middle-income countries, acknowledging the challenges that high-income countries also face when it comes to addressing mental health. Global health (and global mental health) attempts to recognize and change the power dynamics inherent in international relationships founded on colonial legacies and contemporary economic relationships. It identifies as "global" anything that concerns multiple countries, including shared determinants of health, and communicates the value of shared learning across countries and economies. "The global in global health refers to the scope of the problems, not their location"[4].

In the context of global mental health, shared determinants of health include poor investment in mental health care, inadequate attention to prevention as well as treatment of mental disorders, insufficient human resources, and consequently, limited access and quality of care. Equally important are transnational upstream determinants of mental health such as racial and other forms of discrimination, gender inequality, poverty, unplanned rapid urbanization, global economic downturns, forced migration, and complex humanitarian emergencies due to natural disasters and conflicts. Deficits in quality education, investment in early child development, safe and affordable housing, though local in their manifestations, are prevalent in many countries and ultimately affect mental health and well-being.

Global mental health recognizes a vastly interconnected world and values nurturing that interconnectedness for solving difficult problems through a diversity of perspectives. It operates on the supposition that suffering and well-being are shared

aspects of our humanity and, although distinct social, political, historical and economic drivers shape daily experience, there is promise in collective action.

Without deliberate steps toward mental health equity through multiple routes, the global mental health project falters. One route to global mental health equity is through quality mental health research. The increased investment in mental health research in low- and middle-income countries has led to an expanded evidence base on effective interventions now being implemented in diverse sociocultural settings. Greater resources for research and research capacity-building provide opportunities for more diverse ethnic and cultural populations to contribute to the evidence base, to shape research questions and the approaches to answering them, thereby increasing the likelihood that research outcomes will be of relevance to all of us.

Global diversity in mental health research participants will also permit more progress in the search for etiologies of mental illness. Our understanding of the genetic architecture of schizophrenia and bipolar disorder relies largely on Northern European data[5]. Funding flows, partnerships, and opportunities to engage new populations and pursue locally relevant research are far from equitable and this must remain a goal of global mental health.

Equity in improving population mental health outcomes will require a commitment to designing interventions to tackle social problems that limit the effectiveness of care oriented to the individual[6]. Community leadership and empowerment, alongside engagement of service users to help transform service delivery, could be hallmarks of these interventions.

Equity in the production and dissemination of global mental health knowledge requires prioritization of local cultural perspectives. Leveraging global relationships need not negate local experience. Rather, one strategy of the global mental health community should be to make known the innovation and ideas that come from communities which seldom find a global audience. In a recent initiative on suicide prevention among Arctic Indigenous people, a method was developed to build consensus across a diverse group of international stakeholders[7]. Some members of the team called for a parallel process that would use culturally acceptable methods to relay the particular experiences of specific Indigenous communities. The group applied both methods and integrated the findings in the final report[7].

Even widely experienced processes, such as deinstitutionalization, provide context-specific lessons about leveraging political opportunities into gains for mental health[8]. In many settings, deinstitutionalization and innovations in community mental health coincided with the establishment of post-colonial governments, the end of military dictatorship, or the entry of democracy. For example, the expansion of community mental health services in Jamaica after its independence developed in alignment with local cultural values, distinct from the colonial era[8]. These creative approaches to mental health care are valued, though not always widely disseminated.

Nevertheless, the influence of innovative approaches to mental health from settings with scarce resources pervades global mental health. Integrating peers, lay health workers, primary care providers, as well as technology, into mental health care adds flexibility to mental health service delivery, breaks down traditional hierarchies, and makes care more accessible[9]. Diverse ethnic and cultural groups in high-income countries that face challenges in access to and engagement in care can make use of such varied approaches.

It is possible that the global reach of the social, emotional and economic shocks of 2020 will thrust communities around the world into innovation that benefits mental health. If so, the movements, resources and networks that represent people and projects engaged in global mental health may become increasingly widely accessible. The field offers a transnational community for diverse stakeholders with distinct perspectives who value its aims.

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Optimizing personalized management of depression: the importance of real-world contexts and the need for a new convergence paradigm in mental health

In this issue of the journal, Maj et al[1] have revisited a fundamental tenet of psychiatric medicine, namely, that more precise clinical characterization of patients with depression will enhance the provision of personalized management – and the likelihood of optimal outcomes. The authors have conducted a comprehensive and balanced review of relevant domains, including clinical symptoms, severity of illness, depression subtypes, functional status, staging of illness, neurocognition, medical and psychiatric comorbidities, early life adversity, personality dysfunction, and environmental stressors. They have highlighted the importance of measurement-based assessment and care via the use of instruments both psychometrically sound and amenable to im-

plementation in practice.

Although not aiming to deal specifically with biomarkers, the authors suggest that progress in the identification and clinical use of biomarkers will be facilitated through multidimensional clinical assessment. It is indeed plausible that biomarkers will be found to correlate more closely with dimensions of psychopathology than with categorical diagnostic measures, which often hide important treatment-relevant aspects of illness. As such, biomarkers may become more useful as predictors, modifiers and mediators of response variability.

An analogy with diabetes mellitus seems appropriate: finding an abnormal blood glucose (like a positive screen for depression) mandates a clinical workup across a number of dimensions to inform appropriate clinical management, aided by the use of laboratory tests that facilitate monitoring of progress in response to treatment and in prevention of adverse sequelae.

Viewed from the perspective of someone living with depression, an optimal outcome entails both restoration of a sense of well-being and re-engagement in major social, vocational and family roles. As Maj et al note, these are among the outcomes that matter most to patients. Although reduction in symptom burden is clearly important (because residual symptoms indicate increased risk for a relapsing and chronic course), patients and their family carers hope for the return of pleasure and meaning in life, resumption of major roles, and mitigation of carer burden and its attendant demoralization.

Answering the question "How well is well?" depends, therefore, upon taking both a patient-focused and family-centered approach. Depression does not occur monadically, but more often within a family context. Nor does it occur apart from myriad social, cultural and medical issues. Optimal care involves aiming at more than relief of anguish in the pursuit of personalized management.

To say that depression does not occur "in pure culture" is thus to highlight several real-world contexts in which the more precise clinical characterization of depressed patients needs to occur. Relevant contexts for optimizing depression assessment and management include, among others, sociocultural, medical, and systems-based care-delivery issues. These contexts may be understood as a way of further grounding multidimensional clinical characterization *in vivo*.

With respect to sociocultural context, for example, persons from different racial and ethnic groups vary in their understanding of what depression is, what constitutes acceptable treatment, and even whether treatment is needed at all. For some, "depression" is both stigmatized and stigmatizing. Furthermore, engaging persons living in low-resource settings, very different from high-income countries, may be quite challenging, particularly if family members do not "buy in" to the need for treatment. Using like-ethnic community health workers, as members of a treatment team, can be useful for gaining trust and for promoting engagement in treatment, treatment adherence, and access to community resources needed by impoverished or disadvantaged depressed adults in their journey to full recovery.

Optimizing treatment outcomes, the goal of precise clinical characterization, begs the question of how best to close the world's treatment gap for depression[2]. The treatment gap arises especially from the dearth of mental-health specialty expertise in low- and middle-income countries (as well as in rural areas of high-income countries), where social determinants of ill-health, including depression, may be particularly powerful. Work-force issues further underscore the importance of early interventions to pre-empt or prevent depression in vulnerable people, as Maj et al emphasize in their discussion of staging. The implied analogy to cancer is especially compelling since, as with cancer, early preventive intervention may be curative or at least mitigate down-stream complications. In the case of depression, it may mitigate emergence of treatment resistance, chronicity, and adverse outcomes such as suicide and dementia.

How to leverage mental health expertise broadly in the service of personalized prevention and treatment, therefore, becomes the central question. The use of task-shifting strategies in order to share tasks with primary medical personnel and with community health workers has increasingly found a place in team-based systems of depression prevention and treatment (see, for example, Dias et al[3]). Sometimes called "coordinated" care, such models facilitate improvements in evidence-based assessment and guideline-based delivery of care, informed by mental health specialists in the "hub" of the system.

Models of coordinated and integrated behavioral and medical services, including the use of telemedicine and telepsychiatry, have enabled greater reach than is possible with traditional office-based treatment for depression and for reduction of suicidal behaviors. Shifts in reimbursement for telepsychiatry, where the psychiatrist does not actually have to see the patient face-to-face, is facilitating this change in practice – made even more important by the COVID-19 pandemic and its progeny of depression, anxiety, and prolonged grief disorder.

Maj et al underscore how the heterogeneity of depression (in pathogenesis, clinical presentation, and response variability) often gives rise to difficult-to-treat illness (and hence the need for multidimensional evaluation to understand the origins of treatment resistance). A particularly important aspect of optimizing depression treatment is the need for guidelines that can inform shared decision-making with respect to augmenting, switching or combining treatment modalities to help people with difficult-to-treat or even treatment-resistant depression.

In this context, since the goal of treatment is not only to avoid adverse effects and to get well, but also to stay well, understanding the long-term efficacy, effectiveness and tolerability of different strategies needs further attention. Different patient characteristics, such as neurocognitive function, the presence of suicidal ideation, and varying degrees of medical and/or psychiatric comorbidity will likely moderate, or influence, the strength of response to acute treatment and the durability of response and recovery in maintenance treatment. Personalizing management of depression depends upon identification of such variables, or moderators, as distinct from more general prognostic indicators. One can anticipate that biomarkers will be identified as response modifiers in depression treatment, as has been the case in oncology.

In conclusion, multidimensional assessment, as reviewed by Maj et al, is clearly important for personalizing the care of persons at risk for, or already living with, depression. Optimizing short- and long-term outcomes through multidimensional, patient-centered clinical assessment seems more likely when carried out within the broader sociocultural, medical, and care-delivery contexts in which depression occurs in the real world. Needed now, I would suggest, is a new transdisciplinary, convergence paradigm to inform both research and practice in mental health[4].

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